

# PEDIATRIC WHEEZING STUDY - PATIENT QUESTIONNAIRE

Patient's Name \_\_\_\_\_ History # \_\_\_\_\_  
Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_  
Address \_\_\_\_\_

Date of ER visit	Date of birth	Age
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Sex: M F Race: B W Other

Relationship of person interviewed to patient

- 1) Was your child born at UVA? Yes No 2) Birth weight: \_\_\_\_\_
- 3) Was he/she premature? Yes No 4) Did he/she need O<sub>2</sub> after birth? Yes No
- 5) How long was he/she hospitalized? \_\_\_\_\_
- 6) Was your child breast fed? (circle one) 2 months 2-4 months 4-6 months  
>6 months currently? unknown
- 7) Family or personal history for CF?
- 8) Personal history for: cardiac or pulmonary abnormalities? Yes No  
foreign body? Yes No
- 9) Which family members have or have had problems with:

	<u>Mother</u>			<u>Father</u>			<u>Siblings</u>		
<b>Asthma</b>	yes	no	unknown	yes	no	unknown	yes	no	unknown
<b>Hay Fever</b>	yes	no	unknown	yes	no	unknown	yes	no	unknown
<b>Eczema</b>	yes	no	unknown	yes	no	unknown	yes	no	unknown
<b>Food Allergy (specify)</b>	yes	no	unknown	yes	no	unknown	yes	no	unknown
<b>Any Other Documented Allergies</b>	yes	no	unknown	yes	no	unknown	yes	no	unknown

- 10) Has your child ever had problems with (circle all that apply):
- a) eczema (atopic dermatitis): As an infant? Yes No Currently? Yes No
- b) hay fever (allergic rhinitis)? Yes No
- c) foods which make your child sick? Yes No Describe \_\_\_\_\_
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- 11) Where does your child receive most of his/her medical care? (circle)
- a) Emergency Room d) Prompt Care Centers (HMO)
- b) Clinic (Primary Care Center) e) Health Department
- c) Private Doctor's Office f) Other \_\_\_\_\_
- 12) Has your child ever had problems with wheezing prior to this visit? Yes No
- At what age did this start? \_\_\_\_\_ How many ER visits for wheezing? \_\_\_\_\_
- How many hospitalizations for wheezing? \_\_\_\_\_
- When did this recent attack start? \_\_\_\_\_
- When was your child last seen for wheezing? \_\_\_\_\_

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13) Does your child take medicines for asthma?

	PRN	Daily	Currently (How much?)
Beta agonist, inhaler	_____	_____	_____
Beta <sub>2</sub> -agonist, p.o.	_____	_____	_____
Beta <sub>2</sub> -agonist, inhaler	_____	_____	_____
Steroid, p.o.	_____	_____	_____
Steroid, inhaler	_____	_____	_____
Theophylline	_____	_____	_____
Cromolyn	_____	_____	_____
Other	_____	_____	_____

14) Who spends most time taking care of your child? \_\_\_\_\_

15) Does your child attend day care, nursery school, grade school? (circle one)

16) Does anyone smoke at day care or nursery school? Yes No Not known

17) How many people are living at home? Adults \_\_\_\_\_ (18 years or older)  
Children \_\_\_\_\_ (less than 18 years)

18) How many people smoke at home? \_\_\_\_\_ (Mark an "X" under each that applies.)

Other

	<u>Mother</u>	<u>Father</u>	_____	<u>Patient</u>
a) $\leq 5$ cigarettes/day				
b) $\geq \frac{1}{2}$ pack/day				
c) cigars or pipe regularly				
d) smoking location				

19) Parent education level? \_\_\_\_\_  
mother father

20) In what kind of dwelling do you live? (Circle one.)

a) house	d) trailer
b) townhouse/duplex	e) other _____
c) apartment (basement, ground floor, other)	

21) How is your home heated? (Circle all that apply.)

a) wood stove	d) heat pump
b) kerosene heater	e) other (oil or gas) and comment on forced air through vents _____
c) electric baseboard	

22) Exposure to animals?	Inside	Outside
Cat	_____	_____
Dog	_____	_____
Other _____	_____	_____

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